



SERVICE AGREEMENT / CONSENT FOR TREATMENT

Bette D. Harris Family and Child Clinic

The Family Institute at Northwestern University is committed to strengthening and healing families from all walks of life through clinical service, education and research. The Family Institute offers a wide range of high quality behavioral health care through our staff practice and sliding-fee-scale clinic.

Each location's hours are by appointment only. Please be aware that children under 12 years old cannot be left alone in waiting rooms. If your children are not participating in your session, please plan for their care.

TERMS OF AGREEMENT:

- I. **SERVICES:** Services may include, but are not limited to: family, couple, individual and group therapy, as well as psychological testing, school consultation and other diagnostic services as recommended by the clinician. Services may also include the participation of parents/guardians and other significant family members, when appropriate. You or your clinician may suggest other kinds of services (non-direct) outside the scope of normal therapy that may be billable separately such as writing or reviewing letters, reports, etc. Recommendations for treatment are first discussed with and approved by clients. Family Institute clinicians working with multiple members of the family in different modalities (e.g., individual, couple or family therapy) will, with your consent, consult with each other and share information in order to provide effective and coordinated care. Information provided by those participating in couple or family therapy is shared among members participating in that type of treatment. Within our clinic, treatment length will be evaluated based on progress towards mutually agreed upon goals for therapy.

_____ (Client initials)

- II. **ELECTRONICALLY FACILITATED PSYCHOTHERAPY:** Your clinician may provide electronically facilitated therapy, such as a therapeutically oriented email exchange. Before electronically mediated psychotherapy can be initiated your clinician will conduct an in-person assessment and review limits, if any, to ensure your confidentiality.

_____ (Client initials)

- III. **SUPERVISION & CLINIC CLINICIANS:** Service provided in the Bette D. Harris Family and Child Clinic is provided by clinicians who are receiving advanced training as psychotherapists and are supervised by at least one senior staff clinician on a weekly basis. Clients have a right to know the identity and credentials of the senior supervising clinician(s) involved with their care. It is expected that your clinician will set goals with you for treatment and work on



SERVICE AGREEMENT / CONSENT FOR TREATMENT

Bette D. Harris Family and Child Clinic

goals established in an assessment. If you are still in treatment at the end of your clinician's training at The Family Institute (your clinician will notify you of their expected end date), your clinician will review the status of these goals with you and consider whether further treatment is indicated and if so, where it would be best for that to take place and with whom.

_____ (Client initials)

IV. FEES: Clients are expected to pay all fees and co-payments at the time of service.

If clients become delinquent in payment of fees, The Family Institute may suspend or terminate treatment. Unpaid bills are turned over to collection after an appropriate attempt to collect.

_____ (Client initials)

Fees for Clinic Services: No health insurance is accepted in the Bette D. Harris Family and Child Clinic.

Your fee will be \$_____

_____ (Client initials)

V. APPOINTMENT CANCELLATION POLICY: Charges apply for psychotherapy appointments canceled (or changed) with less than 24 hours' notice. Extenuating circumstances are considered when appropriate.

_____ (Client initials)

VI. CONTACTING CLINICIANS: Clients may leave confidential messages for their clinicians on the voice mail system of The Family Institute at any time. The Family Institute does not provide after hours or emergency services. For after hour communication with your clinician, please leave an email or voicemail message. In case of emergencies, please call 9-1-1 or go to the emergency room.

_____ (Client initials)

VII. COMMUNICATIONS: Periodically, The Family Institute sends news and updates on its various programs and activities. You will receive eNewsletters, helpful Tips of the Month, donor stewardship materials and invitations from The Family Institute. If at any time you wish to stop receiving these communications, please send written communication to the Privacy Officer of The Family Institute, 618



SERVICE AGREEMENT / CONSENT FOR TREATMENT

Bette D. Harris Family and Child Clinic

Library Place, Evanston, IL 60201 or click "Unsubscribe" in the footer of any received email.

VIII. AUDIO AND VIDEO RECORDING: For the Bette D. Harris Family and Child Clinic, clinicians-in-training routinely record sessions by audio and/or video in order to review their work with supervisors. Audio and video recordings are considered protected health information and will not be released or shown without consent.

I/We grant permission to The Family Institute to make video and/or audio tape recordings with me/us and my/our family for supervision or clinical consultation. I/We will always be notified when tapes are being made, and I/we may refuse video and/or audio taping of interviews at any time.

_____ (Client initials)

Client does not consent to recording

I/We grant permission to The Family Institute to make video and/or audio tape recordings with me/us and my/our family for instruction and teaching. I/We will always be notified when tapes are being made, and I/we may refuse video and/or audio taping of interviews at any time.

_____ (Client initials)

Client does not consent to recording

IX. FOID MENTAL HEALTH REPORTING REQUIREMENT: As per Illinois Firearm Concealed Carry Act, all physicians, clinical psychologists and qualified examiners are required to notify the Department of Human Services (DHS) within 24 hours of determining a person to be a Clear and Present Danger to themselves or others, Developmentally Disabled or Intellectually Disabled, regardless of the provider's practice, the person's age or any other diagnosis of this person.

_____ (Client initials)

X. MANDATED REPORTING: All clinical service providers at The Family Institute are mandated reporters. This obligates them to comply with the Abused and Neglected Child Report Act that states that any worker "having reasonable cause to believe a child known to them in their professional capacity may be an abused or neglected child shall immediately report or cause a report to be made to the Department." All mandated reporters in the State of Illinois are also required to



SERVICE AGREEMENT / CONSENT FOR TREATMENT

Bette D. Harris Family and Child Clinic

report suspected or reported "abuse, neglect or financial exploitation" of individuals over the age of 60 years to the Department of Aging.

_____ (Client initials)

XI. NOTICE OF PRIVACY PRACTICES: By signing, you acknowledge that you have received the Notice of Privacy Practices of The Family Institute at Northwestern University. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

_____ (Client initials)

Client Consent to Terms of Agreement:

I/We, the undersigned, understand this Service Agreement and apply for services at The Family Institute in accordance with this agreement. A signature is required from the parent(s) or guardian(s) who have legal responsibility for medical decisions for children in treatment.

I/We understand that I/we have the right to revoke this consent at any time. This revocation must be in writing to The Family Institute.

Participants in Treatment:

Printed Name Signature Email Address

Printed Name Signature Email Address

Printed Name Signature Email Address

Printed Name Signature Email Address

Printed Name Signature Email Address

Printed Name Signature Email Address



SERVICE AGREEMENT / CONSENT FOR TREATMENT

Bette D. Harris Family and Child Clinic

As guarantor, I am accepting financial responsibility for services received at The Family Institute. I am also responsible for notifying The Family Institute Billing Department if my status as guarantor has changed or if financial responsibility for treatment is a shared responsibility. If I do not inform The Family Institute Billing Department, I remain liable for the charges. _____ **(Guarantor's Initials)**

Guarantor's Name

Signature

Email Address

Family Institute Clinician Name

Signature

Date



CONSENT FOR RELEASE OF INFORMATION
THE FAMILY INSTITUTE

Client Name Birthdate

Street Address City State Zip Code

The undersigned authorizes The Family Institute (TFI) to: [Circle the option(s) that is(are) appropriate] release to obtain from

Name Relationship

Address Phone Number

the following records and information concerning client, for the period of _____ (m/d/y) to _____ (m/d/y).
Initial the category(ies) of information that is (are) appropriate.

- _____ Discharge Summary _____ Treatment Notes _____ Treatment Plans
- _____ Social Assessment _____ Psychiatric Evaluation _____ Correspondence
- _____ Psychological Evaluation _____ Telephone Consultation _____ Progress Reports
- _____ HIV related information (client must sign this separately) _____
- _____ Drug and Alcohol use, evaluation or treatment information (client must sign this separately) _____
- _____ Other (specify): _____

I also authorize re-disclosure of records from the following individuals and/or agencies: _____

This information shall be used for the following purpose (s):

_____ follow-up care _____ placement _____ treatment planning _____ other (specify) _____

This consent expires on _____. If no date is specified, the consent shall be valid only on the date received for this particular consent for release of information. I understand that I may revoke this consent in writing at any time but that such revocation is effective only with respect to any future requests for disclosure and does not retroactively apply to any disclosure made by _____ in reliance on this release prior to the date it receives a revocation from me. I also understand that any written revocation must be accompanied by the signature of a witness.

I understand that the consequence of my refusal to consent, if any, would be: _____

Date Signature of client (required if client is 12 years of age or older)

Date Signature of parent or guardian (required if client is under 18 years of age or has been adjudicated incompetent)

Date Witness

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, no person or agency to whom any of this information is disclosed may re-disclose such information unless the person who consented to this disclosure specifically consents to such re-disclosures.

Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization for such re-disclosure.

Effective August 1, 2005, The Family Institute requires a copying fee for anyone requesting records (i.e., patients, attorneys, insurance carrier) in the amount of \$20 for up to 20 pages of material, plus an additional \$.10 per page beyond 20. Waivers of this fee will be considered upon written request to the medical records department.